TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Universal DME LLC

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-16-3854-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
August 29, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim has been out way past their 45 days for payment and we feel like they are dragging us along. We should be paid for services rendered because we have submitted the appropriate paperwork needed for review."

Amount in Dispute: $913.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The codes billed on MFDR M4-16-3854-01 re packaged with the facility fee and therefore no further reimbursement is due."

Response Submitted by: Broadspire P.O. Box 14351, Lexington, KY 40512-4351

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 18, 2016	E0675, E0673	$913.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 790 – This charge was reimbursed in accordance to the Texas medical fee guideline
   - D73 – Services denied at the time authorization/precertification was requested
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

- 18 – Exact duplicate claim/service
- 350 – Bill has been identified as a request for reconsideration or appeal
- 790 – This charge was reimbursed in accordance to the Texas medical fee guideline
- A31 – Services reviewed by nurse
- B50 – No reimbursement recommended as this service should be included in the hospital/ASC billing
- D00 – Based on further review, no additional allowance is warranted
- D98 – Reimbursement not recommended in accordance with the official fee schedule guidelines
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code applicable
- W3 – In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requester seeks additional reimbursement in the amount of $913.00 for E0675, RR – "Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system)" and E0673, NU – "Segmental gradient pressure pneumatic appliance, half leg" rendered on January 18, 2016.

   The requestor states, "We did not need authorization for this item per the rule 134.600."

   The respondent states, "No surgical services other than implants if elected by the facility are separately reimbursable. Therefore, no additional payment is due under this invoice."

   The insurance carrier denied the disputed services with claim adjustment reason code D73 – "Services denied at the time authorization/precertification was requested" during the original adjudication of the medical claim on February 15, 2016.

   Upon reconsideration, the carrier denied with claim adjustment code B50 – "No reimbursement recommended as this service should be included in the hospital/ASC billing" on September 16, 2016. Thus, the denial for preauthorization was not maintained and will not be considered in this review.

   The division finds that the durable medical equipment are subject to the requirements of 28 Texas Administrative Code 134.203 (b) which states in pertinent part,

   > For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
   >
   > > (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

   Review of the submitted medical claim finds the place of service submitted on line 24(B) is 22. The definition of this place of service is; "22 On Campus-Outpatient Hospital."

   The Medicare payment policy for durable medical equipment found at www.cms.gov, Claims Processing Manual, Chapter 20, Section 10.2, B(2)(a) finds in pertinent part,

   > *Payment cannot be made for equipment for use in an institution classified as:*
   >
   > > *a. A participating hospital,*

   Therefore, the carrier's denial is supported. No additional payment can be recommended.

2. Based on the information presented, the Division finds the durable medical equipment was provided in a hospital setting. Therefore, the applicable provisions of Rule 134.203 (b) do not allow separate payment of the services in dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		October 21, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.